Baltimore County Department of Health

Community Health Needs Assessment:

2017 Updates

Healthy people living, working and playing in Baltimore County

2017 QUALITATIVE DATA UPDATES

As described previously, limitations in the BCDH's ability to gather data and input from certain populations within the county have impacted the extent to which these populations and their related health needs were discussed throughout this assessment.

The following section addresses areas for continued improvement related to the collection of qualitative data for these population groups.

Qualitative Limitations/Gaps in 2014-15 CHNA Data

Populations that were under-represented in the qualitative data gathered included the following:

- Male population
    - While 47 percent of the County's 2014 population was male, only 28 percent of web-based community survey respondents and 38 percent of the telephone survey respondents were male. In total, only 31 percent of total survey respondents were male. The male population as a percentage of total population in Baltimore County is expected to remain at 47 percent in 2019, further demonstrating the need for additional targeted approaches to increase the number of male respondents in future surveys.
- Under 15 and 15-44 age population
    - No residents under the age of 15 responded to either survey. When the County's population was adjusted to exclude the under 15 age cohort, under-representation of the 15-44 year old age cohort also became apparent. Of Baltimore County's 2014 population over 15 years old, 47 percent were between 15 and 44. Only 32 and 31 percent of respondents to each survey, respectively, and 31 percent of the combined survey respondents were within this age cohort. Both age cohorts as a percentage of total 2019 population in Baltimore County are expected to remain similar to the 2014 percentages, further demonstrating the need for additional targeted approaches to increase the number of respondents within these cohorts in future surveys.
- Hispanic/Latino population
    - While five percent of the County's 2014 population identified themselves as Hispanic/Latino, five percent of web-based community survey respondents and four percent of the telephone survey respondents identified themselves as Hispanic/Latino. In total, only four percent of total survey respondents identified as Hispanic/Latino. In 2019, the

Hispanic/Latino population is projected to increase to over six percent of Baltimore County's total population. As such, this group's under-representation will be exacerbated without improvements in future survey efforts.

- Racial minorities
    - The African American and Asian populations were slightly underrepresented in the survey responses. While 27 percent of the County's 2014 population was African American, only 19 percent of web-based community survey respondents and 30 percent of the telephone survey respondents were African American. In total, 22 percent of total survey respondents were African American. Additionally, five percent of the County's 2014 population were Asian but only one percent of web-survey respondents, five percent of telephone survey respondents, and two percent of total survey respondents were Asian. Both groups are projected to experience increases as a percent of total Baltimore County population by 2019 so additional efforts to ensure adequate input should be implemented.
- Uninsured population
    - Based on data pertaining to Baltimore County in 2012, 11 percent of the population was uninsured. Only four percent of web-based community survey respondents, three percent of telephone survey respondents, and four percent of combined survey respondents reported not having health insurance. The uninsured population was underrepresented and should be included in targeted approaches to increase the number of respondents in future surveys.
- Government-insured individuals
    - Data related to insurance coverage by county was not readily available. As such, the survey responses were compared to data for Maryland overall. In 2012, 28 percent of Maryland's total insured population was covered by government insurance. Comparatively, 19 percent of web-based community survey respondents, 23 percent of telephone survey respondents, and 20 percent of combined survey respondents reported having government insurance (Medicare, Medicaid, or Tricare/VA).

Recommendations for Improved Engagement

- For all survey types, consider requiring responses to demographic questions to obtain accurate and complete data for comparison to overall county demographics.
- When conducting web-based surveys:

    - Post flyers containing links to the survey in clinics/practices.
    - Post links to the survey on social media, particularly if more responses are needed from younger residents.
- When conducting face-to-face surveys:
    - Keep survey questionnaire short and direct.
    - Go to frequently-visited public areas to conduct (grocery stores, banks, churches, etc.).
    - Leverage existing community efforts to improve access to potential respondents, such as attending community or faith-based health forums or screening drives.
    - Include adequate signage to assure participants of survey validity and "officialness."
- Continue to develop both English and Spanish versions of the survey.
- Monitor demographics of completed surveys and adjust targeting for underrepresented groups. For example:
    - Develop coordination efforts with programs recommended for uninsured/underinsured residents[1].
    - Target surveys for areas that are demographically diverse, particularly with underrepresented groups.

[1] http://www.baltimorecountymd.gov/Agencies/health/healthservices/uninsuredservices.html#other

"Clipboard" Survey Tool

The following section contains basic education on how to conduct a face-to-face survey, the questionnaire that was used to gather information, and the associated findings.

Basic Education regarding how to Conduct a Survey[2]

When conducting a face-to-face survey, it is best to target populations of specific interest and to conduct interviews in areas that are demographically diverse to ensure that numerous cohorts are represented in the results. Keeping the survey direct and short in length increase the chances of getting complete responses.

When conducting face-to-face surveys in public areas, the surveyor should take efforts to ensure that respondents can participate in a semi-private area where others cannot overhear their responses. Some respondents may answer questions differently when others are present or within earshot which can bias the results.

In order to accommodate any potential language barriers, bilingual surveyors or the presence of two surveyors (one who can conduct surveys in English and one who can conduct in Spanish) is important. In addition, the clipboard survey itself should be available in each language.

It is recommended that the surveyor does not read the answer choices aloud when asking the survey questions. Rather, read the question and allow the respondent to provide their answer then read back the most appropriate answer choice to record as their response. If they specifically ask for the answer choices or seem to struggle to provide a response, then read the choices aloud for them to select their response.

To ensure that surveyors are familiar with the survey tool and comfortable making assumptions regarding which answer choice is most appropriate, it is recommended that the surveyors conduct practice surveys among themselves. Since many of the responses provided may not directly match an answer choice, these practice sessions will help the surveyors learn how to categorize responses within the provided answer choices.

When a survey has been completed, the results should be immediately placed in a secure location where it should remain until the analyses phase.

[2] Training was provided by Ascendient staff in September 2017 on-site at BCDH.

Community Survey Questionnaire and Findings

The BCDH (alongside MedStar Health) developed a community survey which was made available to the public both electronically via the BCDH website and physically during a community health fair held on September 23, 2017. Both Spanish and English versions were made available to the public. For the purpose of this report, the following charts and tables summarize the responses gathered from all versions of the survey. The survey gathered information from 470 respondents; however, the number of respondents may vary by question.

The survey was comprised of 33 questions that focused on gathering feedback in five key areas: healthcare access and use, community health concerns and behaviors, factors that impact community health, community resource needs and community strengths, and demographics. Please see below for a summary of survey findings, the survey introduction, as well as all survey questions and associated results.

Summary of Findings

The 2017 survey includes the results of all web-based, staff and community member clipboard survey, and independent paper surveys which yielded 470 surveys in the total sample. The results of the 2017 qualitative responses show continued trends from the 2014-2015 CHNA.

In particular, the 2014-1015 priority related to the impact of mental and behavioral health/drug use on health remains an area of concern among the public. Alcohol and drug addiction and mental health conditions were two of the top three most important health problems selected with 59 percent and 36 percent of responses, respectively. When asked to identify the most important health behaviors affecting the community, alcohol and drug abuse and smoking/tobacco use were the top two most frequently selected choices with 67 percent and 52 percent, respectively. Further, when asked which resources/services are most needed in the community additional substance abuse service and mental health services were two of the top three most frequently selected choices with 37 percent and 34 percent, respectively.

Housing problems/homelessness was the most frequently selected social/environmental problem affecting the health of the community with 34 percent of responses. Affordable housing was the second most frequently selected resource/service needed with 35 percent of responses. Further, availability/access to health insurance was the third most selected social/environmental problem with 29 percent of responses.

Issues related to both health insurance/costs and transportation were noted as recurring barriers as to why people have difficulty accessing care. Six percent of respondents believed that a medical provider had treated them unfairly because of the type of insurance they had while four percent believed they were treated unfairly because of their income. The top three selected reasons why people in the community do not get health care were all related to costs and insurance as follows:

- Cost – too expensive/cannot pay – 82 percent
- No insurance – 54 percent
- Insurance not accepted – 41 percent

Overall, the majority of respondents believe the community does have strengths with only 12 percent stating that the community has no strengths. The most frequently selected strengths pertained to good medical providers, good healthcare, and being a good place to raise children. Of the 10 specific statements provided, all 10 yielded at least 40 percent of respondents agreeing that the statement was a strength within the community.

Community resources commonly noted as being capable of addressing these issues included government departments (Social Services, Aging, Health) and programs (WIC/Medicare/Medicaid), various drug, alcohol, and mental health programs, various transportation services, and community organizations (senior centers, churches, food banks, etc.). The need for additional funding of community programs as well as more public awareness that such programs exist were noted as being necessary.

With regards to the demographic composition of the 2017 survey respondents, the survey sample remained heavily skewed towards female and non-minority population cohorts. This may mask variances in needs that exist within minority communities.

Geographically, respondents mentioned that there are variances in access to care and other services, such as transportation, depending on where one lives within the County. In addition, the public knowledge of available services and programs varies from area to area as well. In particular, the western portions of Baltimore County as well as other rural areas were mentioned as being underserved communities. Of note, the majority of survey respondents reside in the southeastern geographies of the county. As such, the responses are not statistically representative of the entire county which was expected given that this survey was conducted as a convenience sample rather than a targeted, statically valid sample of residents.

Survey Introduction

Dear Community Member:

MedStar Health and Baltimore County Department of Health would like to learn more about the health needs of your community. Your voice can be heard by answering a few questions, which will take less than 15 minutes.

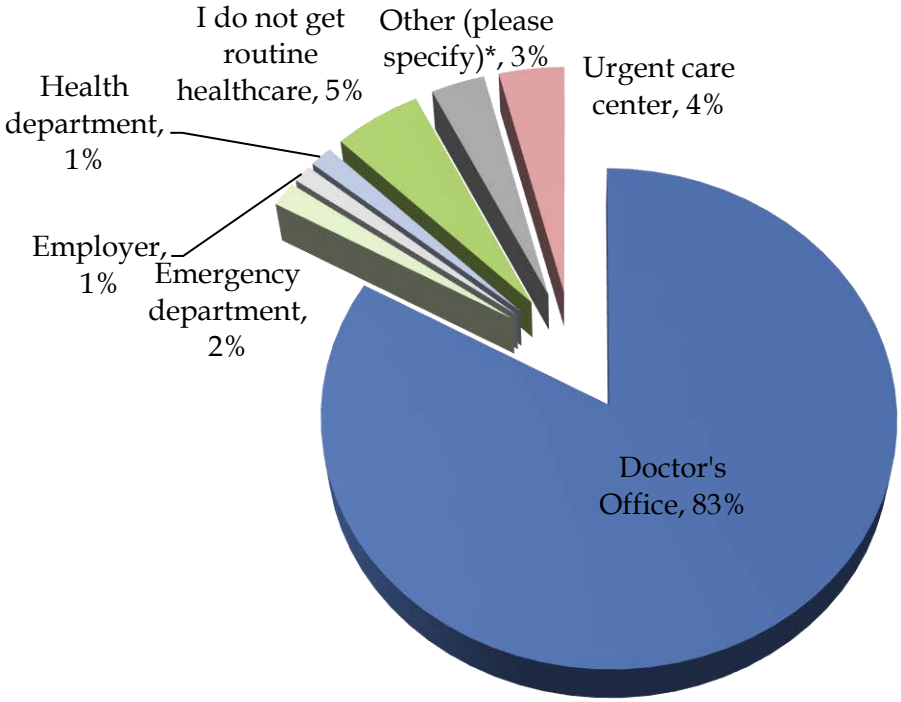
Your input will help us learn more about health needs and the role MedStar Health and Baltimore County Department of Health can play in helping everyone live a healthy life. We do not ask for your name or any information that may be used to identify you, so your privacy is totally protected. A final report will be free and publicly available on MedStar Health's website by June 30, 2018.

If you need help taking this survey, or if you have questions, please call Raquel Lamptey at 410- 772-6910.

Section 1: Healthcare Access and Use

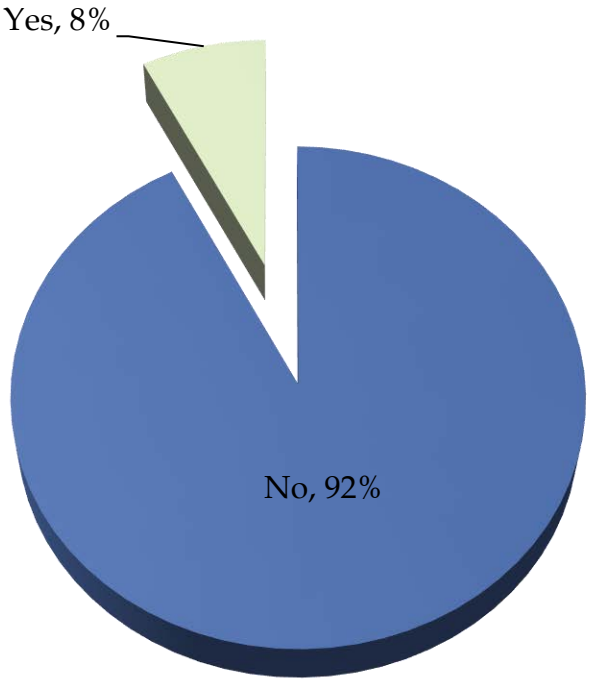
Please answer a few questions about healthcare services.

1. Where do you get your routine healthcare? (Select one option)

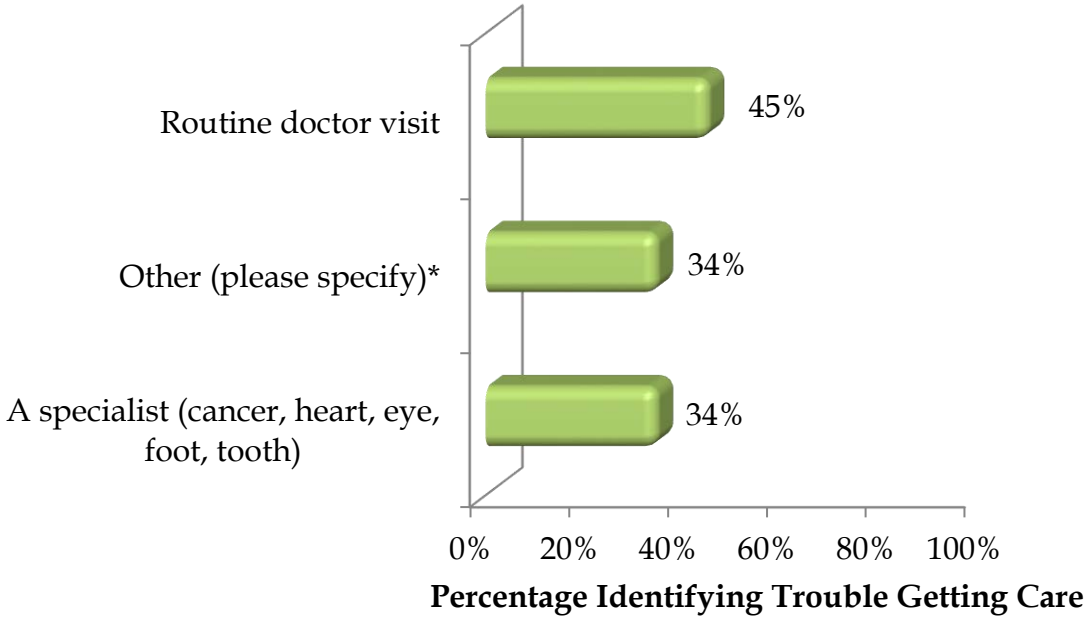


*Other responses included Health Care for the Homeless, Kaiser Permanente, Veterans Affairs, private doctors, and the Primary Care Center.

2. **In the past 12 months, did you have a problem getting healthcare?** (Select one option. If Yes, go to Question 3. If No, skip to Question 4.)

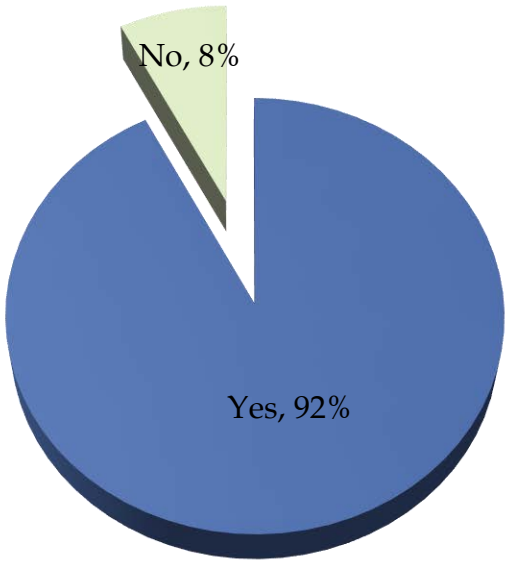


3. **Where did you have trouble getting healthcare?** (Check all that apply)

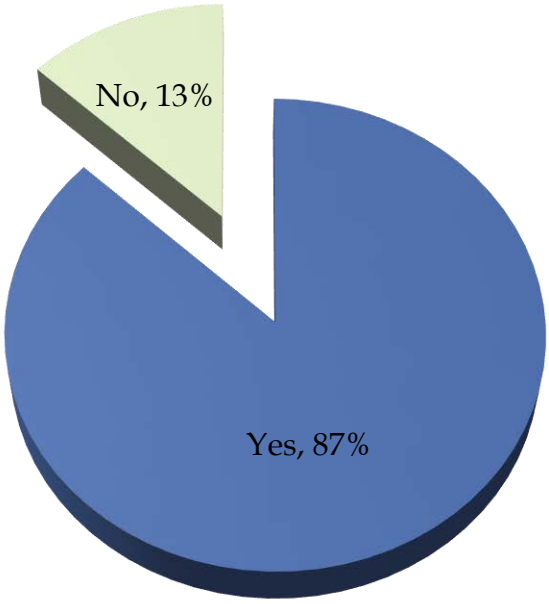


*Other responses included those who did not have trouble getting care, dental visit, GYN visit, imaging visit, hepatology visit, sick visit, pharmacy visit, as well as issues related to transportation and insurance.

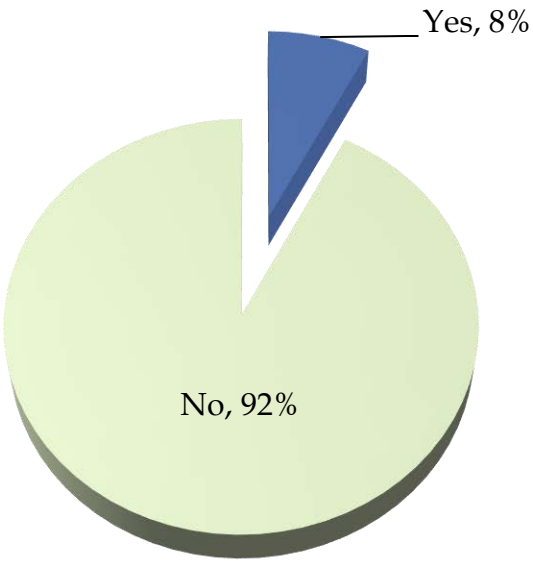
4. **Do you think your medical provider understands your racial and cultural background?** (Select one option)



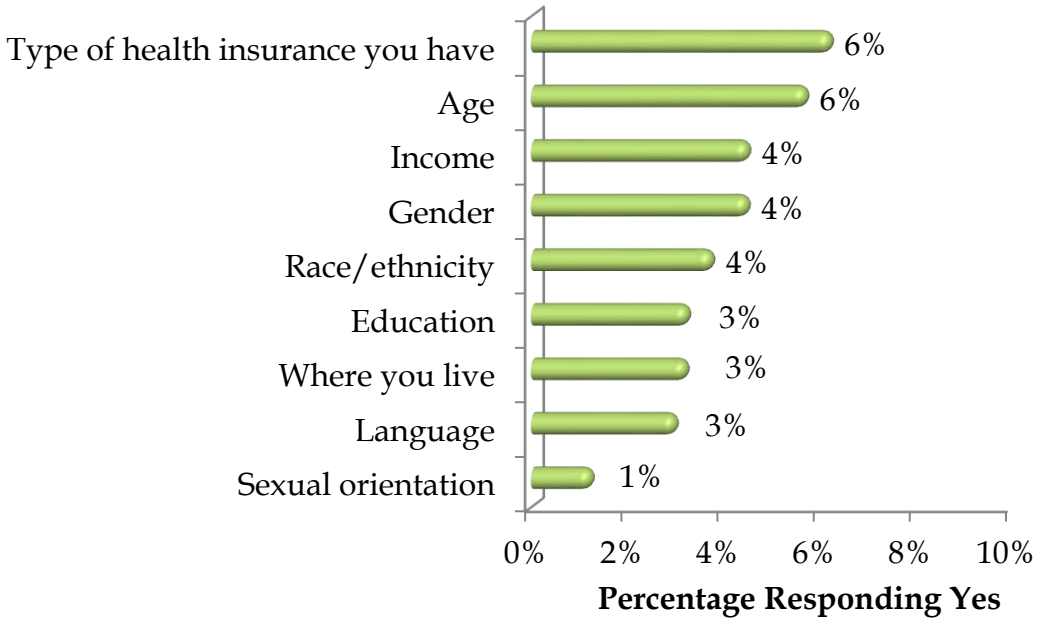
5. **Do you think your medical provider delivers healthcare that takes your racial and cultural background into account?** (Select one option)



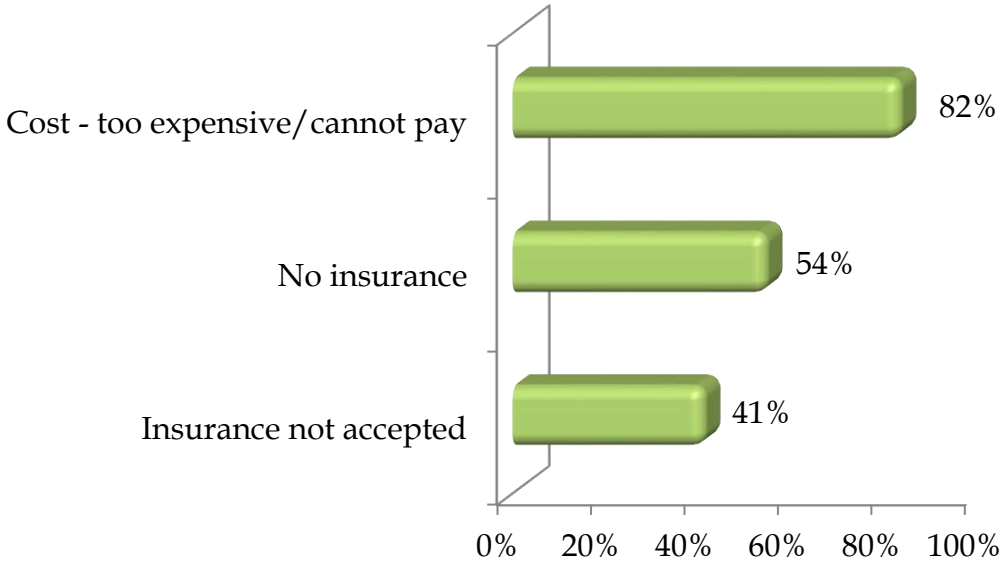
6. **Within the past 12 months, has a medical provider assumed things about you that were not true because of your racial and cultural background?** (Select one option)



7. **Within the past 12 months, have you felt a medical provider has treated you unfairly because of:**



8. **What are the three (3) most important reasons why people in your community do not get health care?**



Percentage Identifying Issue as 1 of 3 Top Reasons

9. **List a few solutions to address the top three (3) issues you selected in question 8 that prevent community members from getting healthcare.**

Responses listed were summarized. Key themes included:

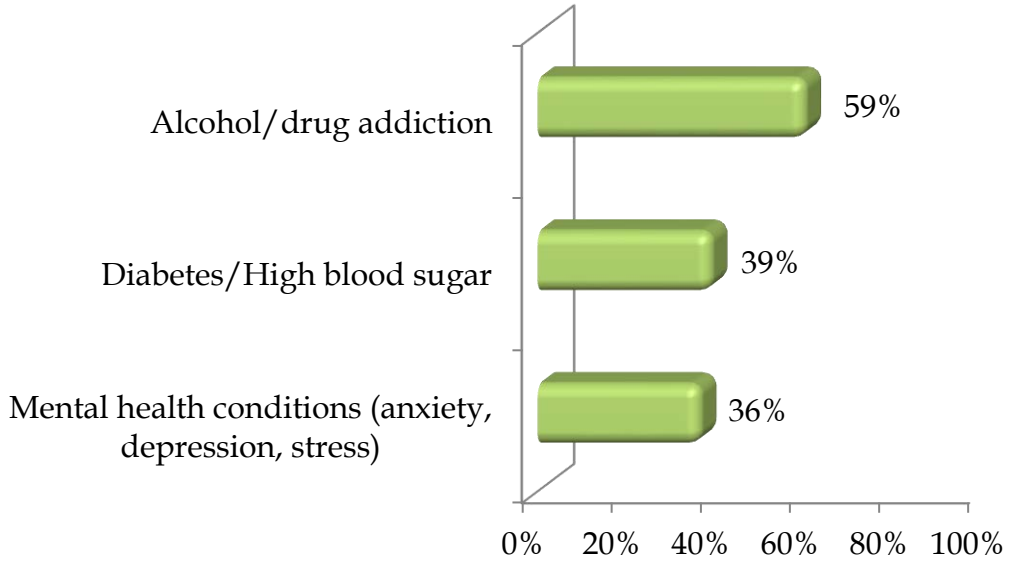
- Changes to the healthcare system (better insurance coverage, more affordable insurance, change in healthcare policies and programs, better access to care/providers locally, transparency, more community liaisons/case workers to help navigate the health system, don't allow practices to turn people away due to insurance contracts or lack thereof, etc.)
- More education about health prevention and disease management
- More focus on ensuring language barriers do not exist (materials in Spanish, bilingual advocates and staff) and ensuring that health insurance for the Hispanic community exists (need to understand the needs of community, fear of legal statutes, lack of social security numbers/work limits health insurance access)
- Better transportation/mobility options (more bus stops, direct pick-up/drop-off shuttle services for medical practices, etc.) or home visits

10. **List any resources (programs, organizations, etc.) available in your community to address these issues.**

    Responses listed were summarized. Key themes included:
    - Departments of Social Services/Aging/Health
    - Healthcare for the Homeless
    - WIC/Medicaid/Medicare
    - Medical Taxi/CountyWide Rides/other transportation services
    - Various senior centers, hospitals, clinics, and community health fairs
    - Churches
    - Esperanza Center, St. Clarke
    - Not aware of any/not sure/do not know

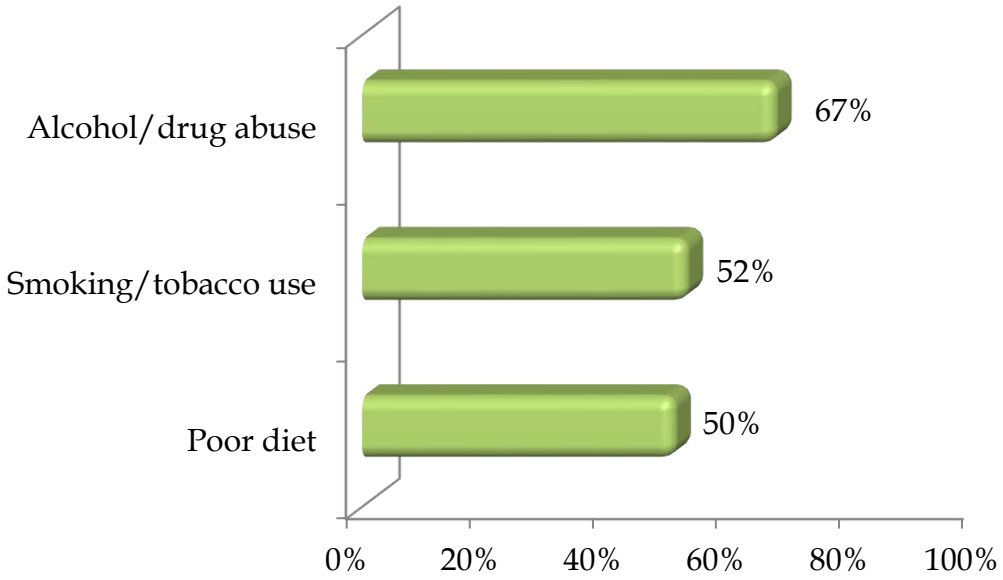
Section 2: Community Health Concerns and Behaviors
Please answer some questions about the health of your community.

11. **What are the three (3) most important health problems that affect the health of your community?**



Percentage Identifying Issue as 1 of 3 Top Health Problems

12. What are the three (3) most important health behaviors that affect the health of your community?



Percentage Identifying Issue as 1 of 3 Top Health Behaviors

13. List a few solutions to address the top three (3) health problems and behaviors your selected in questions 11 and 12 that affect the health of your community.

Responses listed were summarized. Key themes included:

- Improve education and provide more community outreach and communication
- Drug and alcohol abuse treatment options and cessation programs
- Better wellness and nutrition efforts (make fresh foods less expensive/more accessible, more promotion of exercise)
- Make healthcare more affordable and increase access to health insurance
- Increase access to/availability of dental services
- Increase focus on children and teens (better abuse reporting systems, more after-school activities/etc.)
- Make neighborhoods safer, increase the number of shelters

14. **List any resources (programs, organizations, etc.) available in your community to address these health issues?**

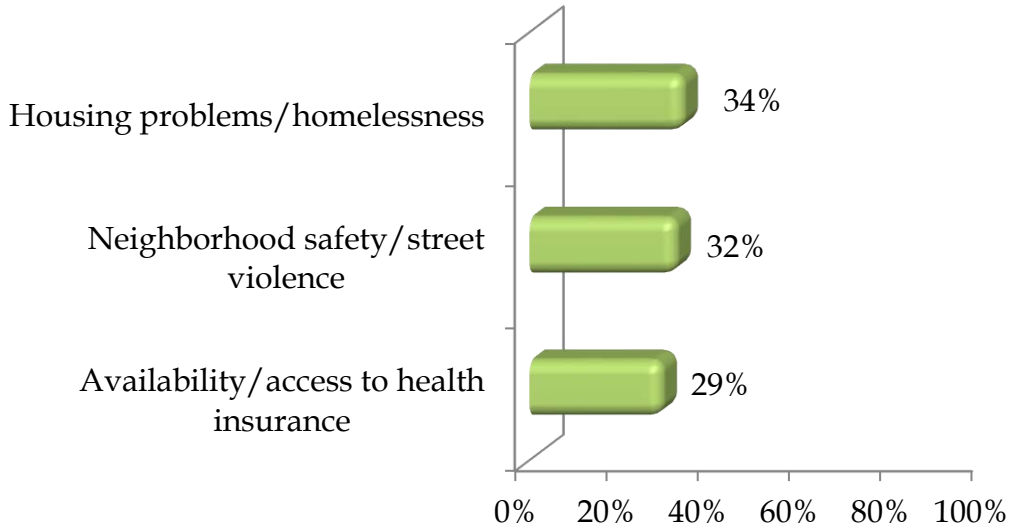
Responses listed were summarized. Key themes included:

- Alcoholics Anonymous/Narcotics Anonymous/National Alliance on Mental Illness
- Social Services programs/County government departments and programs
- Churches
- Big Brother, Boys and Girls club and similar programs
- Smoking cessation initiatives
- Senior centers
- After-school programs and recreational activities
- Not applicable/not sure/do not know

Section 3: Factors that Impact Community Health

Please answer some questions about your community.

15. **What are the three (3) most important social/environmental problems that affect the health of your community?**



Percentage Identifying Issue as 1 of 3 Top Social/Environmental Problems

16. List some solutions to address the top three (3) social or environmental problems you selected in question 15 that affect the health of your community.

Responses listed were summarized. Key themes included:

- Access to affordable childcare
- Access to affordable housing
- Access to better schools and educational/job training opportunities
- Access to more affordable transportation
- Access to affordable healthy foods
- Increase job opportunities
- Make neighborhoods safer
- Additional community outreach
- Additional places for recreation
- Better access to health insurance

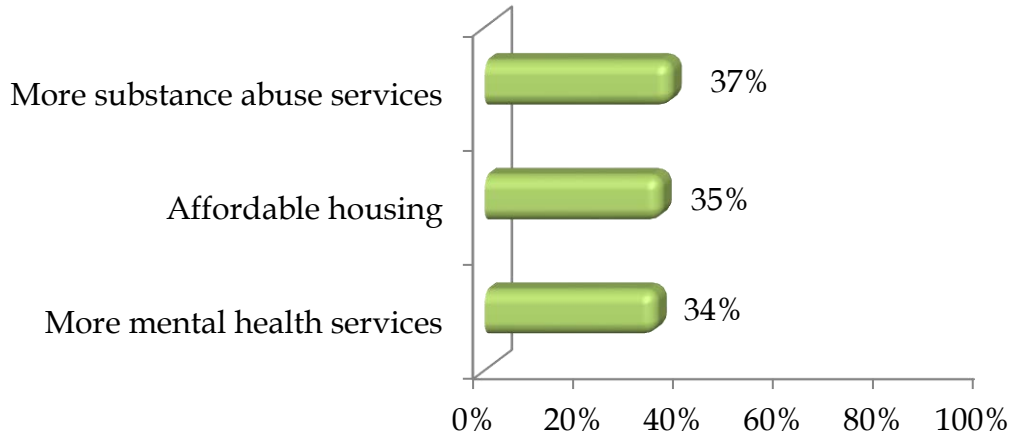
17. List any resources (programs, organizations, etc.) available in your community to address these social or environmental problems.

Responses listed were summarized. Key themes included:

- Social Services/Health departments
- Senior Centers
- Farmer's markets, food banks
- Community College of Baltimore County Learn, Earn, Achieve, Progress (LEAP) Program
- Community organizations and recreation centers
- Schools
- Recycling centers

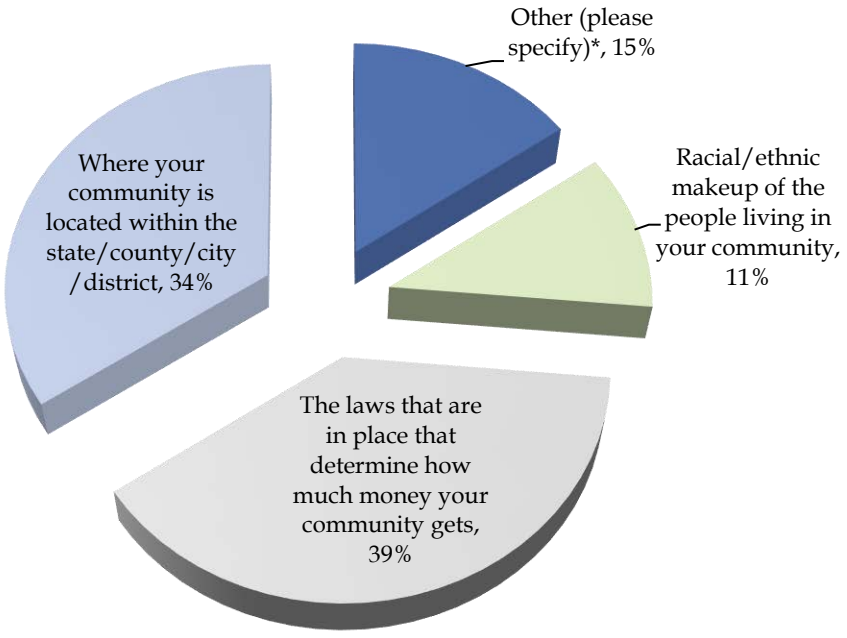
Section 4: Community Resource Needs and Community Strengths
Please answer some questions about your community resources.

18. What are the top 3 resources/services that are needed most in your community?



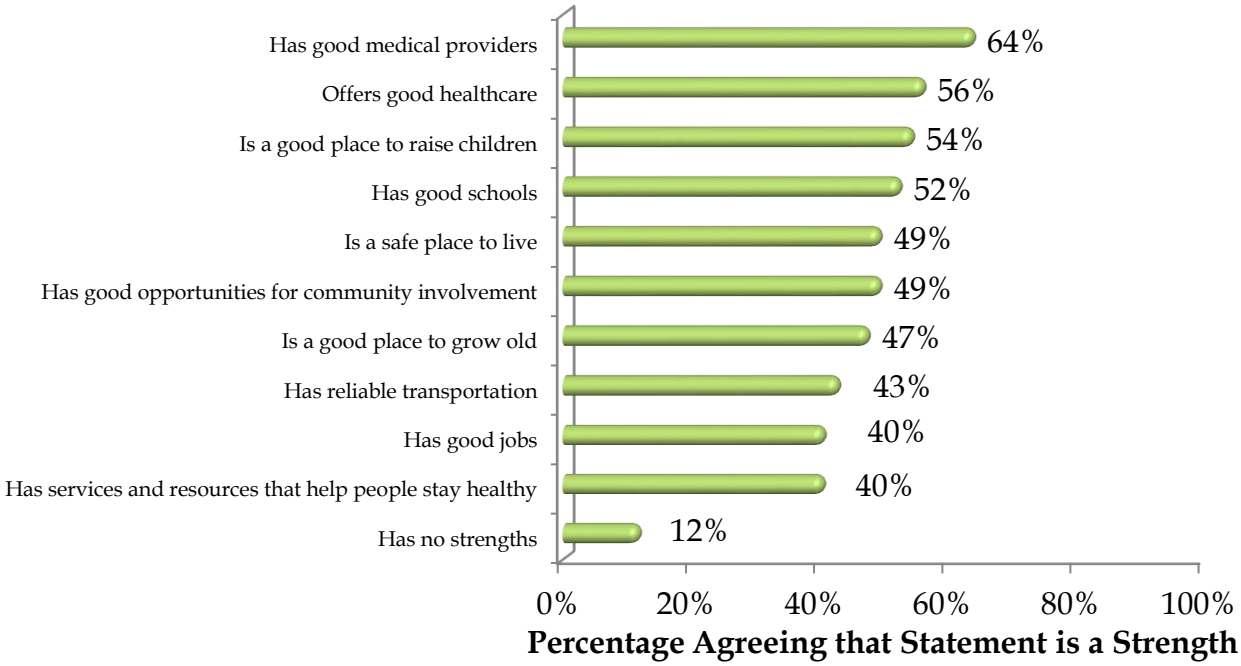
Percentage Identifying Issue as 1 of 3 Top Needed Resources/Services

19. What is the main reason your community does not have the needed resources/services you selected in question 18? (Select one option)



*Other responses included ageism, lack of education, lack of funds, lack of knowledge about available resources, lack of behavioral health treatment options, and the need for increased focus from politicians and revised laws/guidelines.

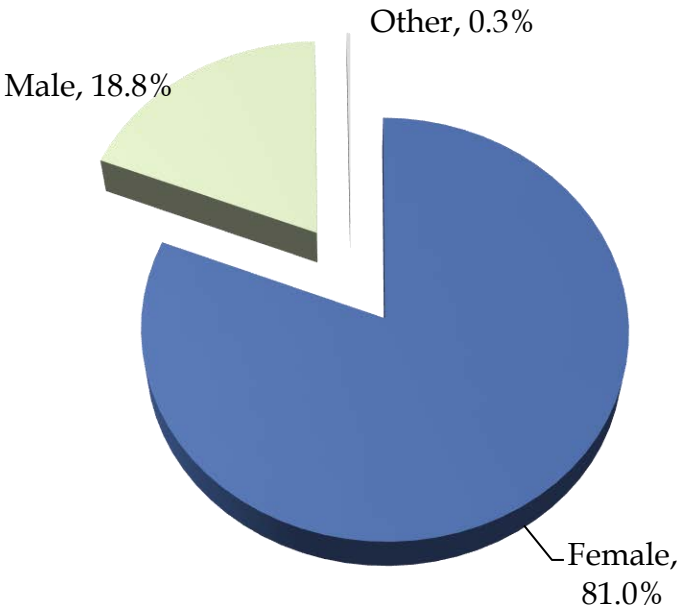
20. What are the strengths of your community?



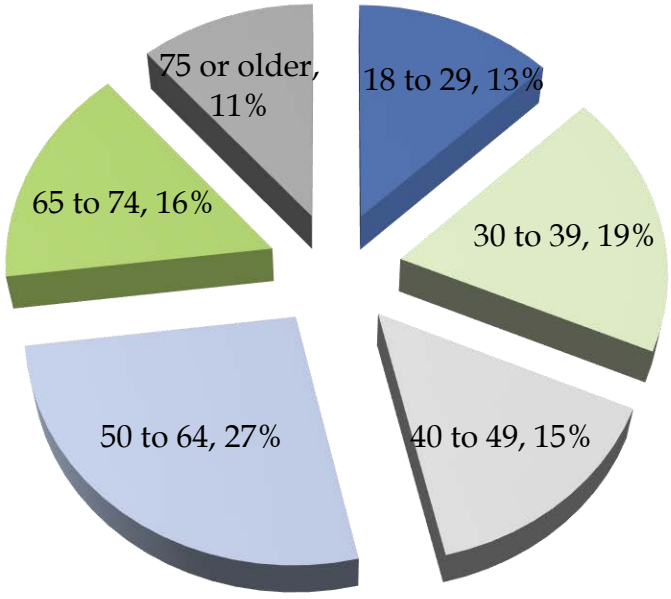
Question 20 also allowed respondents to write-in any community strengths that were not explicitly stated in the statements above. Other strengths noted included churches, people who care, and good healthcare (although it's not affordable). Additionally, it was noted that both good and bad areas exist within any community.

Section 5: Demographic Information
Please complete information about yourself.

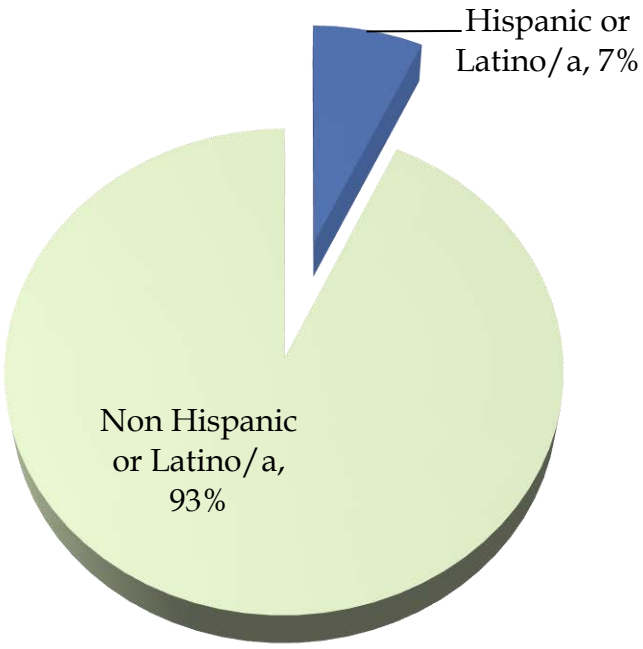
21. What is your gender? (Select one option)



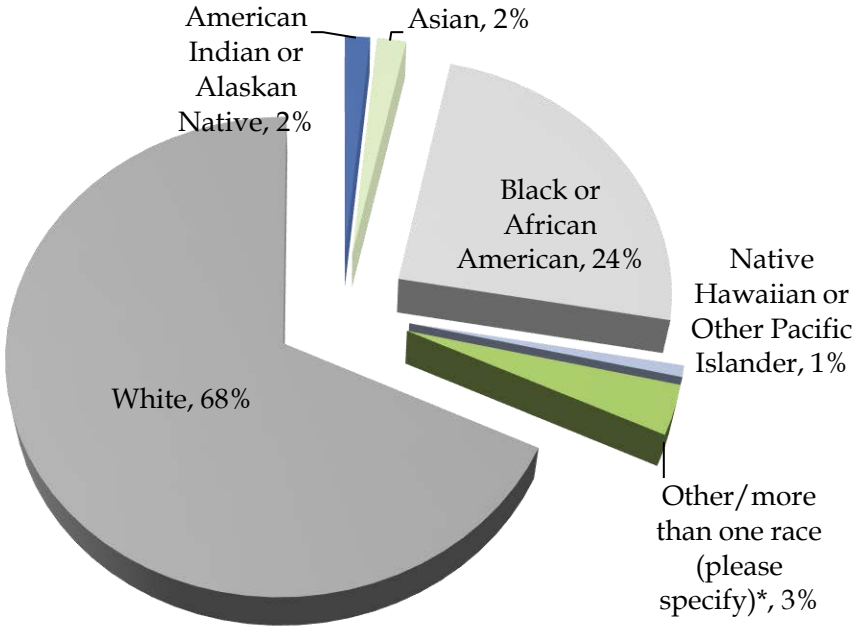
22. What is your age group? (Select one option)



23. What is your ethnicity? (Select one option)

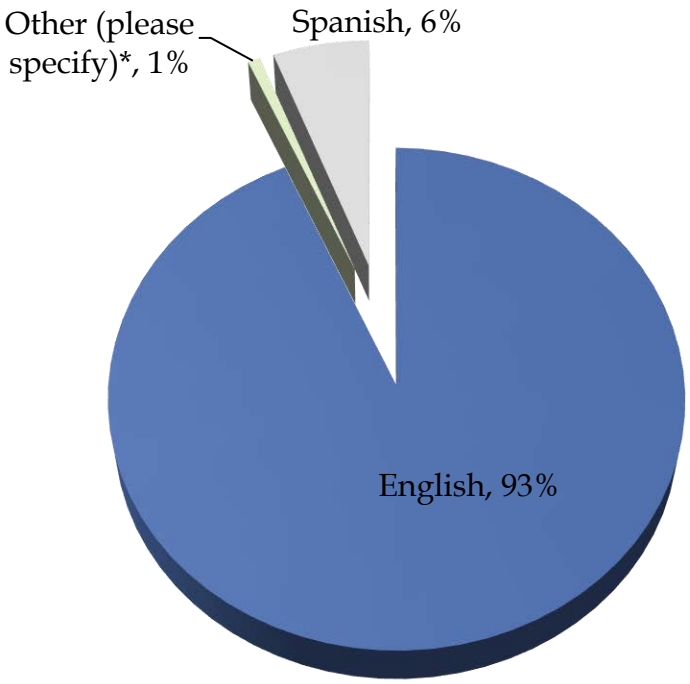


24. What is your race? (Select one option)



*Other responses included American Indian/White, Caribbean American, Cherokee/Black/White/European, Latina, Hispanic, White/Black, and White/Asian.

25. What is your preferred language? (Select one option)



*Other responses included Chinese and Persian.

26. In what ZIP code is your home located?

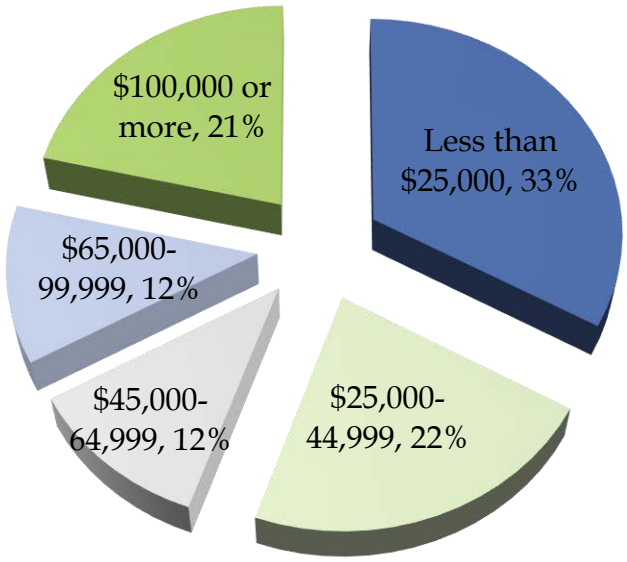
Zip Code of Residence	
Zip Code	**% of Respondents**
21221	14.9%
21220	13.8%
21237	12.4%
21222	7.8%
21206	6.3%

Zip Code of Residence	
Zip Code	**% of Respondents**
21224	3.7%
21236	3.7%
21234	3.4%
21014	2.6%
21228	2.0%
21128	2.0%
21015	1.7%
21204	1.4%
21212	1.4%
21207	1.4%
21087	1.1%
21286	1.1%
21050	1.1%
21211	1.1%
21219	0.9%
21093	0.9%
21085	0.9%
21047	0.9%
21009	0.9%

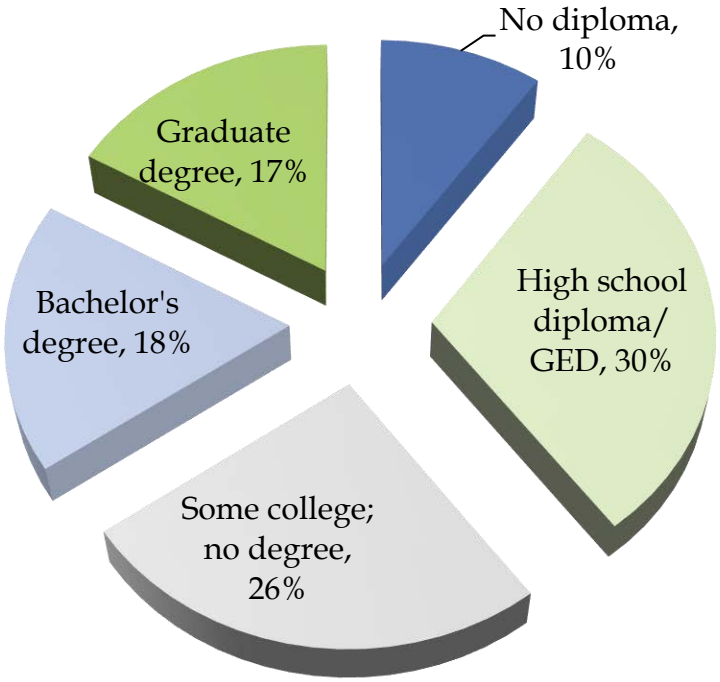
Zip Code of Residence	
Zip Code	**% of Respondents**
21213	0.9%
21205	0.6%
21030	0.6%
21244	0.6%
21217	0.6%
21133	0.6%
21209	0.6%
21214	0.6%
21136	0.6%
21117	0.3%
21216	0.3%
21215	0.3%
21162	0.3%
21230	0.3%
21218	0.3%
21132	0.3%
21201	0.3%
21403	0.3%
21903	0.3%

Zip Code of Residence	
Zip Code	**% of Respondents**
21229	0.3%
544	0.3%
21231	0.3%
21017	0.3%
21157	0.3%
21223	0.3%
21040	0.3%
21035	0.3%
21401	0.3%
21225	0.3%
21807	0.3%
21227	0.3%
21111	0.3%
21061	0.3%
Total	**100.0%**

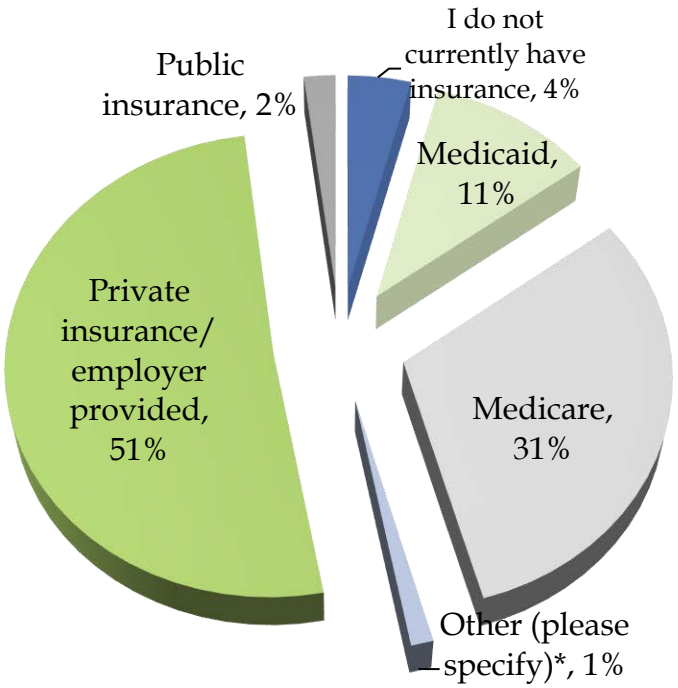
27. What is your approximate average household income? (Select one option)



28. What is the highest level of school you have completed or the highest degree you have received? (Select one option)

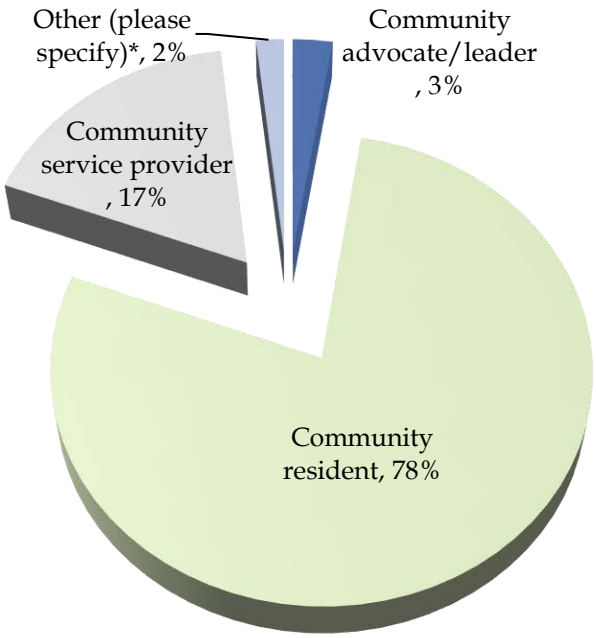


29. What is your source of health insurance? (Select one option)



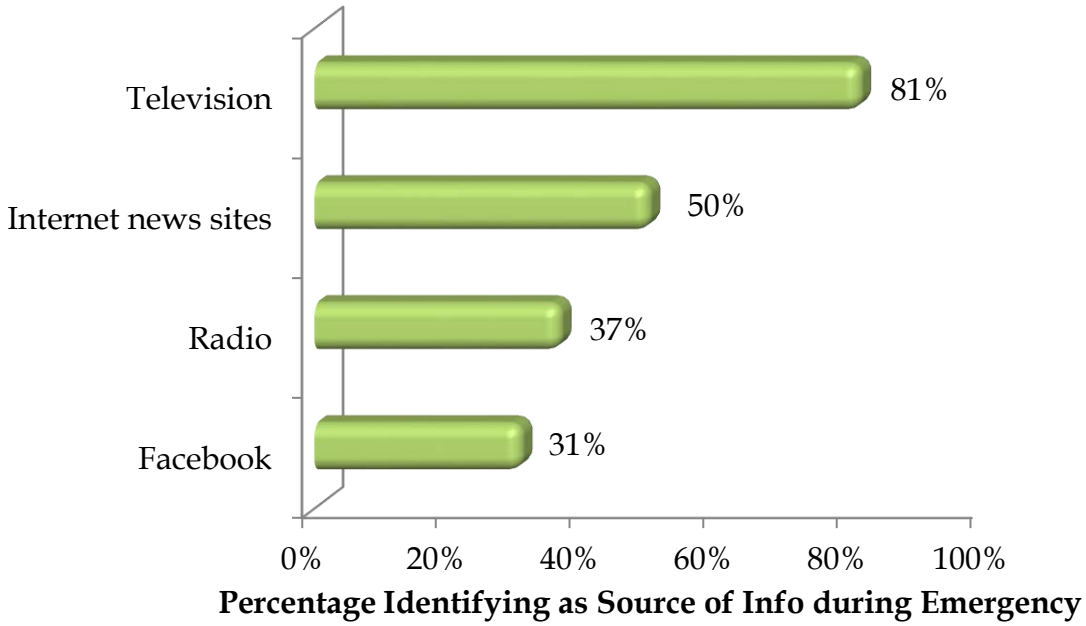
*Other responses included State retiree insurance and Veteran Affairs.

30. What is your role in your community? (Select one option)

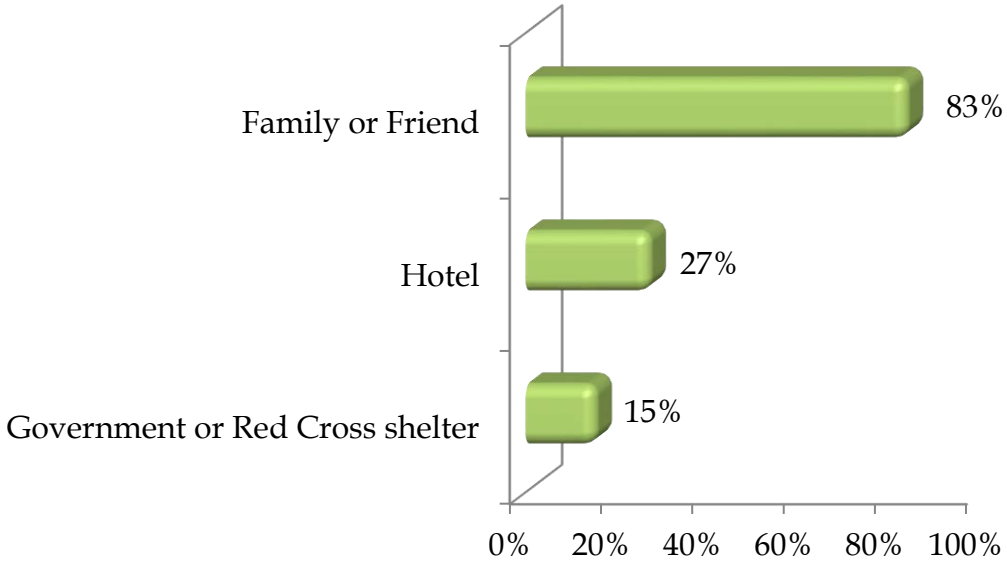


*Other responses included homeless, retired RN, and senior center volunteer.

31. Where do you go to get information during an emergency? (Check all that apply)

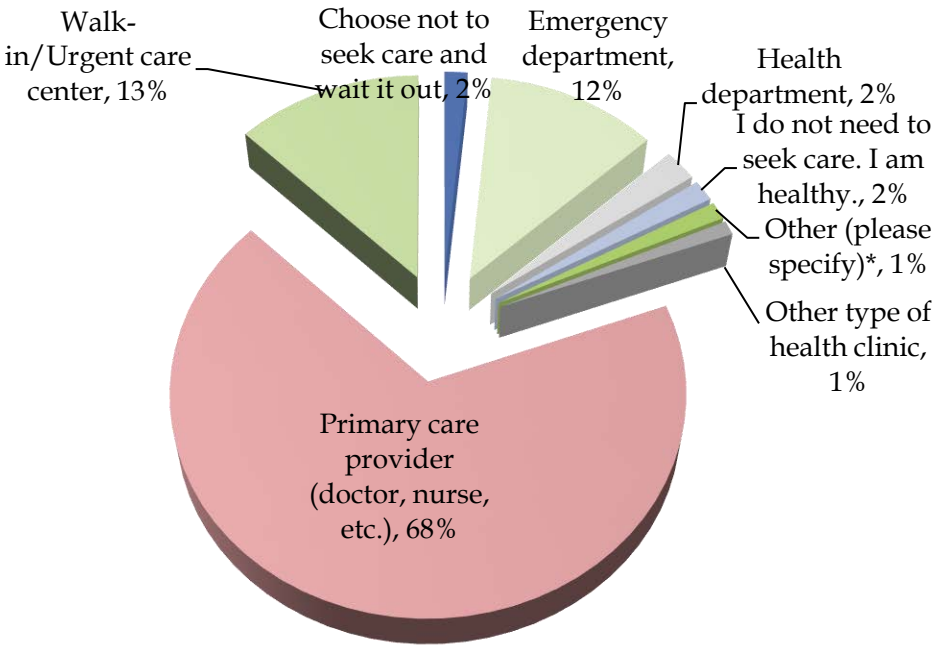


32. If you were ordered to evacuate (leave) your home for more than 1 day where would you go? (Check all that apply)



Percentage Identifying as Location in Event of Evacuation

33. Where do you most often seek medical attention (go to a doctor) when you need it? (Select one option)



*Other responses included Veteran Affairs and Kaiser Permanente.

2017 QUANTITATIVE DATA UPDATES

The impact of mental and behavioral health/drug use was identified as a priority need that existed in five of the Councilmanic districts and as well as for Baltimore County as a whole based on the data collected during the BCDH's 2014-2015 CHNA process.

Since that time, more recent quantitative data have been released that indicate that this area of need has been further exacerbated within Baltimore County. The County has experienced increases in the rate of emergency department visits due to addiction-related conditions, the rate of emergency department visits due to mental health conditions, and the rate of drug-induced deaths. The rate of suicides has remained relatively stagnant over recent years.

Further, an overdose crisis, particularly related to the use of opioids, has swept across the nation. Although these data were not incorporated into the 2014-2015 CHNA, the significance of this recent increase and its impact on Baltimore County requires that an analysis of overdose data be included within this update.

Each of these factors is discussed in more detail below. Please note, many of the sources of comprehensive data provide information that are trailing from the perspective of time. As a result, some of the more recent significant increases are not yet fully reflected in the data provided below.

Emergency Department (ED) Visit Rate due to Addiction-related Conditions

The rate of ED visits for addiction-related conditions in Baltimore County has continued to increase from 1,290.4 per 100,000 in 2013 to 1,390.1 per 100,000 in 2014. Although, this rate is slightly less than the overall 2017 Maryland target of 1,400.9 per 100,000 set by the SHIP, it remains an area for continued focus.

Due to data limitations, the data pertaining to ED visit rates due to addiction-related conditions were only available at the county level.

Emergency Department Visit Rate due to Mental Health Conditions

The rate of ED visits due to mental health conditions has increased slightly within Baltimore County from 2,952.4 per 100,000 in 2013 to 2,967.5 per 100,000 in 2014. However, Baltimore County's rate remains lower than the overall 2017 Maryland target of 3,152.6 per 100,000 as set by the SHIP.

Due to data limitations, the data pertaining to ED visit rates due to mental health conditions were only available at the county level.

Suicide Rate

According to data analyzed by the State Health Improvement Plan (SHIP), Baltimore County experienced a rate of suicides equaling 10.2 per 100,000 in the most recently available time period (2012-2014 aggregate). While this is a slight decrease from the 2010-2012 rate (10.6), it remains greater than the overall 2017 Maryland target of 9.0 per 100,000 set by the SHIP as well as the Healthy People 2020 benchmark of 10.2 per 100,000.

Drug-induced Death Rate

According to data analyzed by the SHIP, Baltimore County experienced a rate of drug-induced deaths equaling 20.5 per 100,000 in the most recently available data (2012-2014 aggregate). This rate has increased 19 percent since the 2014-2015 CHNA document was released (up from 17.2 deaths per 100,000 in 2010-2012 aggregate) and remains greater than the overall 2017 Maryland target of 12.6 per 100,000 set by the SHIP as well as the Healthy People 2020 benchmark of 11.3 per 100,000. Prior to the most recently available data, the rate of drug-induced deaths in Baltimore County had remained relatively stagnant. Based on this evidence, this is a growing problem that should be a primary focus in prevention efforts within Baltimore County.

Overdose Data

The Maryland Department of Health and Mental Hygiene's Behavioral Health Administration produces annual overdose death reports that includes the number of unintentional drug- and alcohol-related intoxication deaths by the jurisdiction of occurrence and substances related to death, including the following:

- Total Drug and alcohol-related intoxication deaths
- Opioid-related deaths related to the following substances
    - Heroin-related intoxication deaths
    - Prescription opioid-related intoxication deaths
    - Oxycodone-related intoxication deaths
    - Methadone-related intoxication deaths
    - Fentanyl-related intoxication deaths
- Cocaine-related intoxication deaths
- Benzodiazepine-related intoxication deaths
- Alcohol-related intoxication deaths

Nearly all of the data provided in these reports include only the number of deaths related to each substance[3] by place of occurrence not by place of residence. As such, the table below includes the number of deaths occurring in Baltimore County and Maryland overall in 2010 and 2016. The compound annual growth rates (CAGR) for each of the two geographies are also included.

Number of Intoxication Deaths by Place of Occurrence						
Related Substance	Baltimore County			Maryland		
	2010	2016	CAGR	2010	2016	CAGR
Total Drug and alcohol-related intoxication deaths	115	336	19.6%	649	2,089	21.5%
Heroin-related intoxication deaths	42	208	30.6%	238	1,212	31.2%
Prescription opioid-related intoxication deaths	60	67	1.9%	311	418	5.1%
Oxycodone-related intoxication deaths	21	22	0.8%	113	157	5.6%
Methadone-related intoxication deaths	37	36	-0.5%	173	197	2.2%
Fentanyl-related intoxication deaths	6	182	76.6%	39	1,119	75.0%
Cocaine-related intoxication deaths	23	80	23.1%	135	463	22.8%
Benzodiazepine-related intoxication deaths	18	29	8.3%	58	126	13.8%
Alcohol-related intoxication deaths	29	81	18.7%	161	582	23.9%

Growth in intoxication-related deaths in Baltimore County exceeded the state for two substances- fentanyl and cocaine. Fentanyl-related deaths in Baltimore County have experienced rapid growth over the six-year time period among the substances shown

[3] Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum to the total number of deaths.

above, followed by heroin and cocaine. Fentanyl-related deaths are now the second leading substance of intoxication deaths in Baltimore County and are led only by heroin-related deaths.

In total, opioid-related deaths occurring in Baltimore County have increased 20.8 percent annually from 2010 to 2016 compared to 23.5 percent annual growth in Maryland overall.

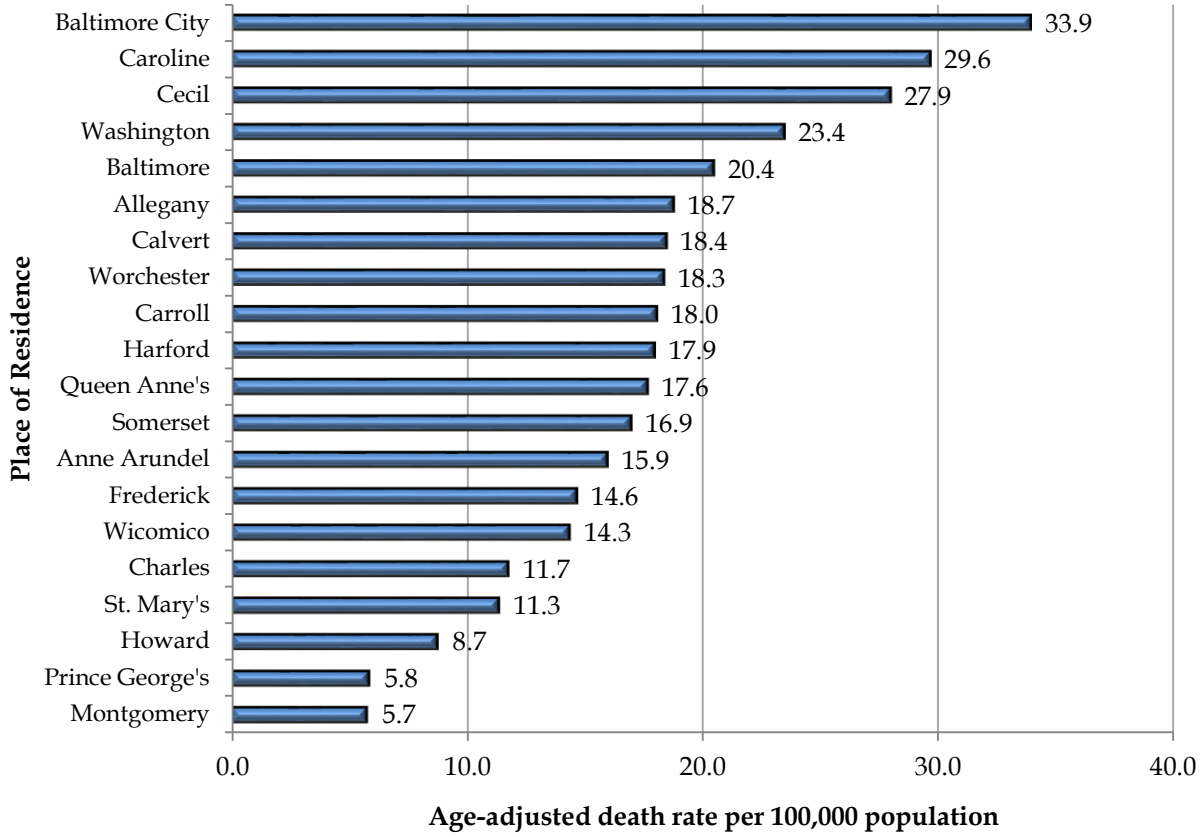
In addition, when the number of intoxication deaths occurring in Baltimore County was analyzed as a percent of total deaths occurring in Maryland, Baltimore County ranked second relative to highest percentage across nearly every substance with the exception of benzodiazepine-related deaths for which it had the highest percentage. Baltimore City held the highest percentage for seven of the nine substances while Anne Arundel County had the highest percentage of oxycodone-related deaths.

Intoxication Deaths by Place of Occurrence in 2016

Related Substance	Baltimore County	Maryland	Baltimore County as % of Maryland	Baltimore County Rank
Total Drug and alcohol-related intoxication deaths	336	2,089	16.1%	2
Heroin-related intoxication deaths	208	1,212	17.2%	2
Prescription opioid-related intoxication deaths	67	418	16.0%	2
Oxycodone-related intoxication deaths	22	157	14.0%	T-2
Methadone-related intoxication deaths	36	197	18.3%	2
Fentanyl-related intoxication deaths	182	1,119	16.3%	2
Cocaine-related intoxication deaths	80	463	17.3%	2
Benzodiazepine-related intoxication deaths	29	126	23.0%	1
Alcohol-related intoxication deaths	81	582	13.9%	2

The 2016 Maryland Department of Health and Mental Hygiene's Behavioral Health Administration Annual Overdose Death Report also includes age-adjusted death rates that allow for the comparison of drug-related death rates among Maryland jurisdictions. Unlike the other data included in the report, these rates are based on the place of residence of the decedent rather than the place where the drug-related incident occurred. Due to relatively small occurrences in many jurisdictions, the age-adjusted rates are based on an aggregated five-year period (2011-2015). Further, due to data limitations rates could only be calculated for total deaths and not deaths related to individual substances.

The following chart includes age-adjusted death rates for total unintentional intoxication deaths by Maryland place of residence from 2011-2015.



Notes: Age-adjusted to the 2000 U.S. standard population by the direct method. Since age-adjusted rates based on fewer than 20 deaths are considered unreliable, rates are only show for jurisdictions with 20 or more intoxication deaths over the five-year period. Rates are based on place of residence, not place of occurrence.

As demonstrated above, Baltimore County ranks as the fifth highest jurisdiction in the state with regards to unintentional drug deaths among its residents.

Due to data limitations, the data pertaining to intoxication deaths were only available at the county level. In addition, quantitative data for 2016 is not yet available from the Division of Vital Statistics or other data sources by Councilmanic district at this time.

Additionally, the BCDH decided that more recent quantitative data pertaining to sexually transmitted diseases[4] and physical inactivity for the County were needed. Measures related to each of these focus areas are discussed in more detail below. Again, please note that many of the sources of comprehensive data provide information that are trailing from the perspective of time. As a result, some of the more recent significant changes may not yet be fully reflected in the data provided below.

Chlamydia Incidence Rate

The incidence rate of chlamydia in Baltimore County has increased every year since 2013, rising from 361.5 per 100,000 persons in 2013 to 503.9 per 100,000 persons in 2016. Given that the overall 2017 Maryland target is 431.0 per 100,000 and the compound annual growth rate for Baltimore County is nearly triple that experienced for the state of Maryland from 2013 to 2016 (11.7 percent compared to 4.2 percent) , reducing the rate of chlamydia should be an area of continued focus for the County moving forward.

While the data pertaining to chlamydia incidence rates were not readily available at the Councilmanic district level, a ZIP code map is available at the following link which can provide some insight as to variation within the County:
https://phpa.health.maryland.gov/OIDPCS/CSTIP/CSTIPDocuments/CTzip.pdf

Gonorrhea Incidence Rate

The incidence rate of gonorrhea in Baltimore County has increased every year since 2013, rising from 71.2 per 100,000 persons in 2013 to 158.9 per 100,000 persons in 2016 for a compound annual growth rate of 30.7 percent. Comparatively, the state of Maryland experienced a compound annual growth rate of 16.2 percent over the same time period. Given the rapid increase in the incidence rate of gonorrhea over recent years, reducing the rate of gonorrhea should be an area for continued focus for the County moving forward.

While the data pertaining to gonorrhea incidence rates were not readily available at the Councilmanic district level, a ZIP code map is available at the following link which can

[4] Source: Center for Sexually Transmitted Infection Prevention, DHMH; Baltimore City Health Department; Maryland Office of Planning, Final as of 5/5/2017.

provide some insight as to variation within the County:
https://phpa.health.maryland.gov/OIDPCS/CSTIP/CSTIPDocuments/GCzip.pdf

Physical Inactivity

According to more recent data available from the Robert Wood Johnson Foundation County Health Rankings, the percentage of adults age 20 and over reporting no leisure-time physical activity in Baltimore County declined from 28 percent in the 2014 County Health Rankings (2010 data) as reported in the BCDH's 2014-2015 CHNA report to 23 percent in the 2017 County Health Rankings (2013 data). The County is also yielding results more closely aligned with the state overall based on the more recent data which shows that 22 percent of Maryland adults report no leisure-time physical activity. Ongoing efforts to continue this positive trend of reducing physical inactivity should be continued.

Due to data limitations, the data pertaining to physical inactivity were only available at the county level.

Summary

Mental and behavioral health/drug abuse are clearly issues that remain prevalent within Baltimore County. In particular, the rising occurrences of fentanyl, heroin, cocaine, and alcohol-related intoxications deaths within both Baltimore County and the state as a whole demonstrate the need for additional resources to address the issues of substance abuse and addiction. While numerous programs and initiatives, such as expanded access to Naloxone, the creation of the Maryland Heroin and Opioid Emergency Task Force and Inter-Agency Coordinating Council, and the 2017 Heroin and Opioid Prevention, Treatment, and Enforcement Initiative, have been implemented across the state over recent years, the need for continued efforts and additional resources persists.

Sexually transmitted diseases are on the rise within Baltimore County as well as the state overall. However, given the rapid increase in incidence since 2013 within the County, additional efforts and resources focused on reducing and preventing chlamydia and gonorrhea could be beneficial.

Improvement has been demonstrated within the County as related to the percentage of physical inactivity since the 2014-2015 CHNA report was released. While the County still yields a slightly higher percentage of physical inactivity than the state, it has reduced the gap significantly.